LOUISIANA PATIENT'S COMPENSATION FUND

STRATEGIC PLAN

FISCAL YEAR 2011-12 THROUGH FISCAL YEAR 2015-16

VISION

VISION

The vision of the Patient's Compensation Fund (PCF) is:

- to protect and maintain the integrity of the Medical Malpractice Act (R.S. 40:1299, et al)
- to help stabilize healthcare costs by providing affordable rates for medical malpractice assurance coverage
- to provide impartial and prompt compensation to affected injured parties of medical malpractice incidents.

To ensure that healthcare costs are minimized for malpractice coverage, PCF will thoroughly evaluate all claims to ensure fair and timely conclusions while maintaining affordable rates. This in turn ensures that healthcare providers choose Louisiana as their location to practice, so that the citizens of the state have multiple options for their healthcare choices.

MISSION

Created by Act 817 of the 1975 Legislative Session in order to guarantee that affordable medical malpractice coverage was available to all private health care providers and to provide a stable source of compensation to injured parties of malpractice.

It is the mission of the Patient's Compensation Fund Oversight Board (Board) to direct the operation and coordinate the defense of the Patient's Compensation Fund (PCF) in a manner that will timely and efficiently meet the needs of the interested parties for whom the PCF was created to serve: the citizens of the state, parties injured as a result of medical malpractice, and Louisiana's private health care providers.

PHILOSOPHY

PCF staff will collect appropriate surcharges for each HCP participating in the fund and will process each claim fairly to ensure adequate compensation is provided to each legitimate injured party.

GOALS

1. The Board shall strive to maintain surcharge rates that are reasonable and affordable for health care providers but adequate to meet the statutorily mandated asset level relative to outstanding and projected liabilities.
2. The Board shall monitor annual claims payments by impartially and objectively resolving claims efficiently and timely.
3. The Board shall maintain adequate technology to provide prompt service to our customers.
4. To be a more transparent, accountable and effective agency.

LINKS TO STATEWIDE INITIATIVES

Louisiana Vision 2020 Link: **Objective 3.3 To ensure quality healthcare for every Louisiana citizen**.
Children's Budget Link: N/A
Human Resources Policies Beneficial to Women and Children: N/A
Other Links (TANF, Tobacco Settlement, Workforce Development Commission, Others) – N/A

DUPLICATION OF EFFORT

No other state agency or department performs these tasks or exercises these controls.

OBJECTIVES

1. ***The Board shall, at all times, maintain the level of assets to liabilities as provided in R.S 1299.44 A (6)(a), with the goal to maintaining a level of approximately 20% over the minimum required at all times.***

   Beneficiary: Private health care providers, insurance companies and the injured parties will be the primary persons benefiting from this objective. With the assured financial stability for the PCF, there will be increased competition among insurance companies who are willing to write policies in Louisiana. The companies from whom insurance companies purchase their insurance will provide coverage at reduced rates, which will in turn be passed along to the health care providers when purchasing coverage. With lower costs, health care providers will be attracted to practice in Louisiana, thus affording Louisiana's citizens' options for their health care choices. Parties injured as a result of medical malpractice will be assured compensation for their injuries, as well as the care needed to ensure they are able to enjoy a satisfactory quality of life, based on their circumstances.

STRATEGY 1.1 – To expedite processing surcharge applications by automating the calculation of surcharge rates

STRATEGY 1.2 – Continue to coordinate with actuarial consultant to refine PCF Rating Manual so classes of providers pay rates commensurate with the risk they pose.

STRATEGY 1.3 – To expedite notification to self-insured providers of their renewal dates so that payment can be received timely. To implement a notification process of impending enrollment deadlines to all other Health Care Providers.

STRATEGY 1.4 - Update and refine the experience rating program which charges the applicable surcharge for the risk associated with those enrolled health care providers who have poor PCF claims history.

STRATEGY 1.5 – To aggressively resist and defend unmeritorious or exaggerated claims while at the same time ensuring resolution of legitimate claims promptly and fairly.

STRATEGY 1.6 – To ensure reserves are established accurately and timely and reevaluated regularly with adjustments made as necessary.

PERFORMANCE INDICATORS:

Input: Annual number of enrolled health care providers, total amount of Surcharges collected and total exposures calculated.

Output: Total surcharges collected annually
Annual Claims Payments
Annual Claims Reserves
Number of enrolled health care providers
Fund Balance

Outcome: Annual percentage increase/decrease in Surcharge rate and compliance with statutorily required asset level relative to liabilities

Efficiency: 80% of renewals processed within deadlines established in PCF's policies
50% reduction in gaps due to failure to receive notice of renewal from primary insurer
.

Quality: Number of delinquent renewals received which results in a gap in coverage should be reduced
Claim files reviewed at least yearly at initial stage and every 6 months when litigation involved

2. Through the Panel activities and claims processes properly review claims for those with merit and thoroughly investigate meritorious claims, evaluating them for liability and damanges.

Beneficiary: Injured parties will benefit from this objective by receiving compensation timely. PCF and health care providers will benefit because when claims are concluded, it saves time (interest) and money (legal fees) for all parties involved.

STRATEGY 2.1 – Maintain statistical medical review panel data and track statutorily mandated timelines by electronic diary system to facilitate timely notices and closures.

STRATEGY 2.2 – Update PCF Medical Review Panel procedural and instructional brochure, supplied to individuals representing themselves and attorneys chosen as attorney-chairperson, so that they will know their duties as well as all statutory requirements relative to the Medical Review Panel process. Conduct meeting of all attorney chairmen to streamline process and provide consistency to handling of panel notices and practices.

STRATEGY 2.3 – To aggressively work to shorten the time frame by 10% from the time a medical review panel opinion is reached until the time the associated claim is closed.

STRATEGY 2.4 – To continually strive to build a closer working relationship with primary carriers, defense attorneys and self-insured providers in order to know as early as possible if a claim has the potential to impact the PCF's layer of coverage. Maintain an up-to-date website to publish information to these individuals.

STRATEGY 2.5 – Proactively pursue joint settlements with primary carrier or self-insured so that PCF can negotiate while liability is still an issue.

STRATEGY 2.6 - Closely monitor and evaluate all payment requests on claims involving future medical payments to assure that expenses are reasonable, necessary and related. When indicated, utilize professional audits of medical bills. Continue to utilize the Department of Labor's Workers' Compensation "fee schedule" for these expenses.

STRATEGY 2.7 – Use defense counsel only on those claims the senior adjusters are unable to resolve.

STRATEGY 2.8 – Supervisors will periodically review pending claims status reports with each individual adjuster.

STRATEGY 2.9 – Unbiased claims counsel review of requests for settlement authority to ensure consistent case evaluations.

PERFORMANCE INDICATORS:

Input: Annual number of claims opened
Annual number of claims closed

Output: Annual number of claims closed compared to opened

Outcome: Percentage of claims closed within five years of filing date

Efficiency: Maintaining at least 100% claims closing persistency
Annual number of claims evaluated and resolved within 5 years of the claim filing date
Less than 20% of claims pending over ten years from date filed
100% of files with Senior Adjusters reviewed at least every 6 months

Quality: Annual number of claims closed within 4 years when no indemnity payment made
Decrease in pending claims over 10 years old
Prevent inflated numbers of pending claims against health care providers

3. To promptly provide accurate information through courteous customer assistance, imaging and accurate data input and to maintain an informative and current web site to increase transparency and accountability of the agency.

Beneficiary: Claimants, health care providers, insurance carriers and their agents, will all benefit from this objective because a highly trained and well-equipped staff will be able to quickly respond to their needs.

STRATEGY 3.1 – Ensure that all new employees attend customer service training within 6 months of hire date and that all supervisors attend their appropriate management courses. All new employees receive Ethics training within 1 year of hire.

STRATEGY 3.2 – Ensure that sufficient staff is available to process claims, panel requests, and enrollment applications at all times. Review workload for each section and establish benchmarks, if not already in place.

STRATEGY 3.3 – Maintain appropriate technology and infrastructure for all employees so that accurate information is available for decision-making and reporting.

STRATEGY 3.4 – Image all incoming panel and provider mail so information is readily available for inquiries and so copies can be quickly provided to insurers, providers and attorneys. Image all claim payments to ensure permanency of the records and provide proof of payments when requested.

STRATEGY 3.5 – Image current paper provider files and closed claim files as time and staff permit. Move towards imaging pending claims files.

STRATEGY 3.6 – Increase transparency and accountability by maintaining up to date financial, claim and panel information on the PCF web site, as well as current rate information, necessary forms, board meeting minutes and important notices.

STRATEGY 3.7 - Make certificates of enrollment available online for current and past year so that providers and those that perform credentialing tasks can readily obtain this information and citizens can verify coverage of health care providers.

PERFORMANCE INDICATORS:

Input: Decrease in computer errors reported to I.T. staff in computer data system (PRISM)
Number of panel, claim and provider files imaged and/or pages imaged
Monthly posting of information and reports on PCF web site.

Output: Number of open provider and closed claim files imaged
Monthly updates to the PCF web site

Outcome: 100% of supervisory staff attend all required training within time allowed by Civil Service.
50% of all current provider files imaged by 2013.
75% decrease in bugs / problems reported in PRISM by 2011

Efficiency: Information is recorded into PCF's database within established deadlines and files are imaged so that they are readily available to those that need them and copies can be provided quickly.

Quality: Increase in information available to those we serve and the public in general and decrease in response time for requests for information
Overall increase in customer satisfaction and decrease in complaints

APPENDIX A

PRINCIPAL CLIENTS AND USERS:

The Patient's Compensation Fund was established for the benefit of these groups:

private health care providers licensed and practicing in the State of Louisiana
parties injured as a result of medical malpractice committed by those health care providers, and
ultimately all citizens of Louisiana.

The health care providers receive:

- Medical malpractice coverage of $400,000, excess of $100,000, at affordable rates.
- The protection of a limitation, or statutory "cap", on damages that can be awarded for claims of medical malpractice of $500,000 plus related medical expenses.
- Entitlement to have all claims initially evaluated by a medical review panel of three health care providers before civil litigation can be initiated.
- Competitive and affordable rates brought about due to the financial stability of the Fund and the resultant attraction that malpractice insurance writers have found to issue policies in Louisiana.

Those parties injured as a result of a medical malpractice incident receive:

A certain and stable source of compensation that will pay up to $400,000, excess of the providers primary source of $100,000, plus all related medical expenses, which includes the cost of custodial care whether it is provided by a business, a private individual, or even a family member.

Citizens of Louisiana receive:

Access to better, more affordable health care as a result of available and affordable malpractice insurance which draws a larger pool of health care providers to Louisiana to practice, especially medical specialists.

APPENDIX B

STATUTORY AUTHORITY:

Act 817 of the 1975 Louisiana legislative session created the Patient's Compensation Fund. The Act is comprised of La. R.S. 40:1299.41 through 40:1299.49. The establishment of the Patient's Compensation Fund is specifically outlined in La. R.S. 40:1299.44.A.

The Patient's Compensation Fund Oversight Board was established by an amendment to Act 817 during the 1990 legislative session, and is found at La. R.S. 40:1299.44.D.

The limitation on damages is found at La. R.S. 40:1299.42.B.

The payment of Future Medical benefits is listed in La. R.S. 40:1299.43.

The Medical Review Panel process is outlined in La. R.S. 40:1299.47.

The PCF Rules and Regulations is found in LAC Title 37-III- Chap.1-19.

APPENDIX C

EXTERNAL FACTORS:

1. The Louisiana Judicial System:

Substantive - liberal or excessive court judgments in regard to damages by either judge or jury.

Liberal interpretations of the facts of a case as to the question of a provider's liability.

Procedural - various aspects of the malpractice statute (La R.S. 40:1299.41 et seq.) are constantly scrutinized by the state courts on the question of constitutionality. In Butler v. Flint Goodrich Hospital of Dillard University et al. the Louisiana Supreme Court held that:

> "Since the legislature's statutory solution to the medical malpractice problem furthers the states purpose of compensating injured parties, it is not constitutionally infirm. Overall, the Louisiana Medical Malpractice Act represents a reasonable but imperfect balance between the rights of the injured and those of health care providers. It does not violate the state or federal constitutions."

The constitutionality of the statute continues to be challenged in the courts. The Medical Malpractice Act and the cap on damages is viewed “as failing to provide the plaintiffs an ‘adequate remedy’ ” as guaranteed under the provisions of La Constitution Article 1 Section 22 by those that challenge it. Even if the Supreme Court confirms prior decisions as to the constitutionality of the cap, the issue will continue to be challenged. Thus there is some degree of uncertainty as to the role and exposure of the PCF.

2. The Louisiana Department of Insurance:

At times in the past the Board's request for rate increases that the consulting actuary has determined to be necessary has been refused by the Department of Insurance. In fact, this has occurred even when the percentage rate increase sought by the Board was significantly less than actuarially indicated. As of 8/15/10, and in accordance with Act 78 of the 2010 Regular Legislative Session, the Department of Insurance no longer regulates the PCFOB and the Board will establish rates in accordance with Act 78.

3. The Louisiana Legislature:

The Legislature could enact amendments to the statute that could make it difficult to achieve the objectives outlined above. Furthermore, the legislature could abolish the PCF and/or the Board.

4. Health Care Providers:

As to risk management, it will be up to health care providers to implement procedures that attempt to reduce the incidence of medical errors. In many instances such procedures entail **additional costs.** Some providers may decide, based upon economic considerations, not to implement such procedures.

Retention of health care providers in the state is at risk, for several reasons. In the past few years, PCF had seen an increase in health care providers participating in the Fund. Economic situations or environmental changes could impact the number of physicians in Louisiana and thus the number of health care providers that enroll in the PCF.

As costs of medical malpractice insurance coverage increase – whether as a result of increased incidents, payouts for claims associated with major incidents in the state, or an increase in the medical malpractice cap – providers will leave Louisiana to practice in more favorable states.

Further, enrollment in the PCF is not mandatory and if less expensive coverage can be provided that the health care providers feel is adequate for their perceived exposure, they may opt out of the PCF all together.

APPENDIX D

PROGRAM EVALUATION:

The strategic planning process began with a review of the existing plan by PCF senior management comprised of the Medical Malpractice Compliance Director, the Claims Manager and the Administrative Director. An evaluation of where we are now and where we want to be was performed. Objectives were developed. An action plan comprised of various strategies to obtain our goals was laid out.

A preliminary plan was developed and presented to the Executive Director for review. Meetings were held with all supervisors to solicit input and to familiarize the supervisors of the steps they would be required to implement to achieve the goals included in PCF's final strategic plan. Once input was obtained from PCF staff, the plan was presented to the PCF Oversight Board for additional input.

PCF realizes that the two sets of customers most directly served by us – health care providers and parties injured as a result of medical malpractice - often have opposing opinions of how we should conduct our business. There is no easy solution to satisfying the needs of both sets of customers. PCF cannot **and does not** set the needs of one group above the other. Striking a balance between the two is the challenge PCF faces daily.

BENCHMARKING:

It has been difficult to find a benchmarking partner against which to measure PCF. Not all states have Patient's Compensation Funds. There is a wide diversity among the operations of the Funds that do exist. Some funds are mandatory; some include only specific types of providers; some are for specific types of injuries; some are administered by state entities; some are handled by third party administrators; some have separate caps on both economic and non-economic damages; most do not include future medical expenses although some do.

Regardless, there have been various statistical studies done by diverse groups in relation to medical malpractice settlements and judgments and the medical malpractice insurance rates across the U.S.. PCF has determined that comparing our operations to these studies is the best avenue for benchmarking progress toward our goals.

One measure of success used by most insurance companies is their percentage of underwriting expense as compared to premiums. "Underwriting expense" represents the overhead of salaries and other costs associated with running a business. In a report distributed in November 2006, Tillinghast, a division of Towers Perrin, reported that underwriting expense over the past ten years has ranged from 16% to 22% of net premiums. In PCF's case, the administrative budget has represented from 1.5% to 2.0% of surcharge collections. PCF is very efficient in accomplishing our mission.

Another measure of success can be the number of claims closed with a payout for damages and the number of claims closed with no payout by the PCF. There are many reasons that claims are closed with no payout including:

- abandonment by the plaintiff
- failure to comply with timeframes as established in the Medical Malpractice Act
- there was no a breach in the standard of care by the health care provider found during the peer review process so the plaintiff did not pursue further action
- damages were below the $100,000 threshold for payment by the PCF
- during discovery in the post-panel process, the case was found to be without merit and concluded without payment.

According to a study compiled by the US Department of Justice, Bureau of Justice Statistics, issued in March 2007, from data submitted by seven states with comprehensive claims databases, the number of claims closed with a payout ranged from a low of 12% to a high of 38%, over the period 2000-2004. During the same period, PCF averaged payouts on 12% – 14% of our claims.

PCF is always mindful of its obligation to parties who have been injured as a result in a breach of the standard of care by a covered, qualified health care provider. Timeliness of compensation being provided to the injured party is important to the PCF. However, since PCF cannot participate in a suit until there is a judgment in excess of $100,000, or until a settlement is reached or PCF has been invited to participate, PCF cannot always close claims as timely as we would like. The PCF strives to obtain information on claims through cooperativeness with insurance companies, defendants, and plaintiffs. Not only does this benefit the injured party, but expenses are lowered through less costly interest payments. According to the US Department of Justice, Bureau of Justice Statistics report, on average claims, are reported between 15 and 24 months after occurrence and resolved within a 26 to 45 months after reporting. Louisiana's statute of limitations requires claims to be reported within 12 months of occurrence but no later than 36 months from occurrence. Once exposure to the PCF level of coverage is reported, PCF resolves claims on average within 24 months. Our goal is to work with underlying insurers and their defense counsel to work together to timely and fairly compensate those that have been injured as a result of medical malpractice.

Appendix E

PERFORMANCE INDICATOR DOCUMENTATION

Indicator Name/Number: Annual number of enrolled health care providers (GOAL I) / 6095

1. Indicator Type/Level: Input / K

2. Rationale: Denotes the number of healthcare providers - individuals, groups, and institutions - that voluntarily pay the surcharges that comprise the monies held in the Patient's Compensation Fund. Consequently, this number represents, at a minimum, the providers that are available to deliver healthcare to the citizens of Louisiana.

3. Data Collection Procedure: Self-Insured providers or primary insurance carriers submit all applicable documentation directly to the PCF office. Such documents consist of applications, certificates of insurance, surcharge payments, self-insured security deposits, etc. Information regarding enrollment is entered into PCF's database and certificates of enrollment are issued to the healthcare provider.

4. Frequency and Timing of:
   - Collection - documentation is submitted and collected daily
   - Reporting - annually for actuarial review

5. Calculation Methodology: Any provider who pays an individual surcharge is counted as a single provider. Hospitals, clinics, nursing homes, surgical centers, dialysis centers, etc., are counted as single providers. Health care providers that are employees of such facilities, but are not required to pay individual surcharges, are not counted separately, but are included in the single provider count of the facility. Physicians, Certified Registered Nurse Anesthetists, Physician's Assistants, Surgical Assistants, Clinical Nurse Specialists, Nursing Practioners, Nurse Mid-Wives, Dentists, and Oral Surgeons are required to pay individual surcharges, so each provider is counted individually. RN's, LPN's, lab techs, radiology techs, etc. are not required to pay individual surcharges if they are employees of enrolled health care providers, so they are not counted.

6. Aggregations or Disaggregating: Total providers are also sub-categorized into:
   - Provider type (physician, hospital, dentist, nursing home, CRNA, All Other, etc.)
   - Physician class (physicians are rated according to 11 classes)
   - Physician specialty (physicians are further categorized as to specialty)

7. PCF Surcharge Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations or Weaknesses: Since participation in the Patient's Compensation Fund is voluntary, not all healthcare providers will be counted. However, PCF does feel that the majority of providers who are eligible DO participate.

9. Management Usage: This information is used by the actuary to determine exposure, which is used in the calculation of surcharge rates. It is also used in the calculation of the statutorily required asset to liability level. Finally, management will use this information to determine staffing levels.

Indicator Name: Total surcharges collected annually (GOAL I) / 6092

1. Indicator Type / Level: Output / K

2. Rationale:This indicator shows how much is paid into the PCF by enrolled health care providers annually.

3. Data Collection Procedure: All payments are sent directly to the PCF Surcharge Section and are posted to PCF's database.

4. Frequency and Timing:
   - Collection - payments are received and are posted daily
   - Reporting – monthly to the PCF Oversight Board, annually to the actuary and as needed for management purposes

5. Calculation Methodology: How much a provider must pay is based upon current rates published annually in the PCF Rate Manual. Through upgrades to PCF's in-house computer system, automation of the rate calculation will ensure that the provider is paying the correct surcharge before posting the payment to the database.

6. Aggregations or Disaggregating: Total surcharge payments are sub-categorized by type of provider, physician class, and physician specialty.

7. PCF Surcharge Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations or Weaknesses: none

9. Management Usage: This information is used by the actuary in the calculation of surcharge rates. It is also used in the calculation of the statutorily required asset to liability level.

Indicator Name: Annual claims payments (GOAL I) / 10401

1. Indicator Type / Level: Output / K

2. Rationale: Represents actual claims expenditures. This indicator shows actual loss experience. It also represents the other important factor analyzed by actuaries to determine recommended rates. Claims payments tracked for 5 or 10 years can help actuaries to develop trends, which aid in determining reasonable and sufficient rates to meet the needs of future claims.

3. Data Collection Procedure: All claims payments are processed by the PCF Claims Section through PCF's database.

4. Frequency and Timing of:
    - Collection – daily
    - Reporting – monthly to the PCF Oversight Board, annually to the actuary and as needed for management purposes

5. Calculation Methodology: The amounts that are paid for indemnity (settlements or judgments) are based upon:
    - The nature and extent of the injury
    - The age of the claimant
    - An evaluation of the likelihood of a finding of liability
    - The jurisdiction
    - The capabilities of the plaintiff attorney
    - Cooperation from the primary insurer, which is a MAJOR yet UNCONTROLLABLE factor
    - Judicial interest exposure
    - Medical expenses already incurred and expected to be incurred in the future.

    Expense payments are based upon actual incurred expenses. Future Medical payments, if determined necessary by a court or by agreement between the parties, are paid as incurred.

6. Aggregations/Disaggregating: Payments are categorized as:

- Indemnity
- Interest
- Future Medicals
- Legal and Other Expenses

7. PCF Claims Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations or Weaknesses: Many of the factors related to settlements of cases are outside the control of the PCF. If the healthcare provider, or his/her insurer, chooses not to timely settle a case, PCF is also on hold. This is a result of case law. When a judgment is reached in a case, PCF is responsible for paying judicial interest, regardless of whether we tried to actively pursue settlement of the claim or not and regardless of whether the healthcare provider paid policy limits or less. Once a healthcare provider settles a claim for policy limits ($100,000), PCF can no longer argue liability, only causation and damages. This limits the PCF's defense actions. In addition PCF must always be cognizant of future medical expenses and legal costs. At times, PCF has been unable to conclude settlement offers in order that other obligations are met.

9. Management Usage: This information is used by the actuary in the calculation of surcharge rates. It is also used in the calculation of the statutorily required asset level. Management uses this information for fiduciary responsibility and settlement strategy.

Indicator Name/Number: Annual claims reserves (GOAL I) / 10399

1. Indicator Type / Level: Output / K

2. Rationale: Represents the estimated liability exposure for a claim. A reserve is set by the Claims Section based upon professional judgment of its value. The reserves are a very important aspect of what the actuaries consider when they analyze data and recommend proposed rate increases/decreases.

3. Data Collection Procedure: The Claims Section establishes the reserves on claims based on available information, payments or judgments on similar cases and records that information into PCF's database.

4. Frequency and Time of:
   - Collection – daily
   - Reporting – monthly to the PCF Oversight Board, annually to the actuary and as needed for management purposes

5. Calculation Methodology: There are a number of factors that the Claims Department takes into consideration when determining the appropriate reserves for a particular claim such as:

    - The nature and extent of the injury
    - The age of the claimant
    - An evaluation of the likelihood of a finding of liability
    - The jurisdiction
    - The capabilities of the plaintiff attorney
    - Cooperation from the primary insurer, which is a MAJOR yet UNCONTROLLABLE factor
    - Judicial interest exposure
    - Medical expenses incurred and expected to be incurred.

6. Aggregations/Disaggregating: Total reserves are also categorized as follows:

    - Indemnity reserves (settlement or judgments)
    - Future Medical reserves (if applicable)
    - Legal and Other Expense reserves

    Additionally, reserves are sub-categorized by provider type and physician class and specialty.

7. PCF Claims Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: A reserve is an estimated, educated guess of the value of a claim based largely on past court cases and settlements. Therefore, it is not an exact science. At settlement or judgment a determination is made as to whether the claimant will continue to incur medical expenses related to the malpractice.

9. Management Usage: This information is used by the actuary in the calculation of surcharge rates. It is also used in the calculation of the statutorily required asset level. Management uses this information for fiduciary responsibility and settlement strategy.

Indicator Name: Annual number of claims evaluated (GOAL II) / 10400

1. Indicator Type / Level: Efficiency / S

2. Rationale: Provides a measure of productivity and workload for Claims. As the adjusters obtain facts about a claim, it is reviewed and evaluated so that it may be brought to closure. Settlement authority must be granted by supervisors, the Claims Manager, the Executive Director and the Board. This information shows the progress of claims through the settlement process. The quicker cases are evaluated by an adjuster, the faster injured parties are compensated.

3. Data Collection Procedure: When a case is assigned to a senior adjuster, an evaluation is performed. As additional information is obtained, additional evaluations are done. When settlement authority is requested, the claims counsel meets to discuss the case. These events will be documented and recorded in PCF's database.

4. Frequency and Time of:
   - Collection – daily
   - Reporting – monthly for management purposes

5. Calculation Methodology: Each case that is assigned to a senior adjuster and each claims counsel meeting will be counted.

6. Aggregations/Disaggregating: none

7. PCF Claims Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: PCF must actively pursue obtaining information on claims as plaintiffs and their attorneys are not diligent about keeping PCF informed. Also, since PCF is not a party to the suit until after there is a judgment in excess of $100,000 or a settlement is reached or invited to participate, information is not readily available on the status of a case.

9. Management Usage: Management uses this information to monitor productivity and workload.

Indicator Name: Number of updates to information on the PCFOB web site (GOAL III) NEW

1. Indicator Type / Level: Output / S

2. Rationale: The need for the individuals and groups the agency serves to have current information relative to the operations, rules, regulations, statutory provisions and expenditures of the PCFOB has been recognized by the Board and the staff. Having current and essential information on the web site and readily available is a tool to be used by others. It is important that the information be up-to-date, accurate and provides the level of information needed.

3. Data Collection Procedure: All updates to the web site will be recorded by the I. T. section staff.

4. Frequency and Timing of:
   - Collection – daily
   - Reporting – quarterly or as needed
   -
5. Calculation Methodology: The PCF will record the number of changes/updates made to the web site.

6. Aggregations/Disaggregating: none

7. PCF I. T. section will be responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: none

9. Management Usage: Management uses this information to monitor compliance.